Mental Health Medication Advisory Committee Meeting Meeting Minutes, Open Session October 28, 2015 at 2 pm – 4 pm		
MHMAC Meeting Minutes Open Session HP Enterprise Services Capital Room 6700 SW Topeka Blvd Bldg. 283 J Topeka, KS 66619 October 28, 2015	**Members Present:** Vishal Adma, MD, MS, CMQ, CPE Holly Cobb, NP Taylor Porter, MD Rebecca Klingler, MD Karen Moeller, PharmD, BCPP Nicole Ellermeier, PharmD Susan Mosier, MD, MBA, FACS, KDHE Secretary/MHMAC Chair Brad Grinage, MD **MCO Representatives Present:** John Esslinger, MD, MMM, - United Healthcare Jennifer Murff, RPh, - United Healthcare Sosunmolu Shoyinka, MD, - Sunflower Katy Friedebach, MD, - Sunflower William Mack, MD, - Amerigroup Lisa Todd, RPh, BBA, - Amerigroup **KDHE Staff Present:** Aaron Dunkel, Deputy Secretary of KDHE Kelley Melton, PharmD, KDHE/DHCF Liane Larson, PharmD, MPH,KDHE/DHCF Carol Arace, KDHE/DHCF Sandra Akpovona, KDHE/DHCF Monica Cuba, KDHE/DHCF	**Representatives:** Sandra Akpovona; KDHE Monica Cuba; KDHE Chris Beal; Otsuka Becky Klingler; KDHE Dan Murray; J&J Roy Lindfield; Sunovion Colin Thommasset; ACMHCK Sara Belfry; KDHE Eric Harkness Sue Lewis; MHAH Kyle Kessler; ACMHCK Nick Reinecker; citizen
TOPIC	**DISCUSSION**	**DECISION**

		AND/OR ACTION
I. Call to Order & Announcements	Opening Secretary Mosier called the meeting to order at 2:05pm. Secretary Mosier: All right, well, we'll go ahead and get the meeting started. We have kind of changed up the table in terms of we have a couple of…well about seven new folks at the table. So, what we are going to do is go around and do introductions again so that everybody knows who everybody is and I will start here with Dr. Klingler. Introductions I'm Becky Klingler. I am a pediatrician in Manhattan, Kansas. I have a faculty appointment to KU and I have a masters in agriculture. Hi! My name is Brad Grinage and I am a psychiatrist. I have a position at the Veterans Administration Hospital here in Topeka, Kansas, and I have a private forensic practice and I'm an MD. I am Karen Moeller. I am a pharmacist but I work at the University of Kansas. I am faculty at the School of Pharmacy. I also work at the University of Kansas Medical Center on the Adult Psych Unit. I am Dr. Taylor Porter. I am a psychiatrist and a Medical Director at Valeo Behavioral Health here in Topeka. Carol Arace an Administrative Assistant with KDHE, Division of Health Care Finance. I am John Esslinger. I am the Chief Medical Officer for United Healthcare's Medicaid plan in Kansas. I am Jennifer Murff and I am the Plan Pharmacist for United Healthcare. I am Sosunmolu Shoyinka. I am a psychiatrist and Medical Director for Behavioral Health at Sunflower. I am Katy Friedebach. I am the Chief Medical Director at Sunflower. I am Bill Mack. I am a psychiatrist and Medical Director at Amerigroup, Behavioral Health Medical Director. My name is Lisa Todd. I am a pharmacist with Amerigroup.	

	Kelley Melton and I am a pharmacist with the Division of Health Care Finance at KDHE. Liane Larson, also a pharmacist at KDHE. I am Aaron Dunkel. I am the Deputy Secretary of KDHE. I am Nicole Ellermeier. I am a pharmacist. I work with Med Track Services and prior to that I spent quite a bit of time working with the Kansas DUR Board. Dr. Vishal Adma, I am a psychiatrist working in Kansas City. I am the Medical Director for KVC, as well as the President for the Kansas Psychiatric Society. I am Holly Cobb. I am a nurse practitioner formerly with Valeo Primary Care now with Oasis Family Medicine Direct Primary Care. I am Susan Mosier, Secretary for the Kansas Department of Health and Environment Sec. Mosier: We have just a couple of announcements. One is a parking announcement to make sure everybody is not going to get towed. So if you are south of the building, we will take a break…and let you move your car because that is where you are at risk of being towed but as long as you are north, east or west… So does anybody have any issues of where they parked today? [No response.] Ok.	
II. Presentation of Psychotropic Drug Data	Sec. Mosier: Then … we asked for financial disclosure of forms and I know we have collected a few of those. I think Liane has handed out those so if you can fill… Dr. Larson: If anyone needs another copy, let me know. Sec. Mosier: …those out today. Yes. And, we wanted to start with the presentation last time. There were questions about what is the status in Kansas. So, we went back to the first quarter of 2015 and also back to the full year of 2014. Particularly, when we were dealing with the age groups that we were talking about for the prior authorization criteria that we discussed last time. And so we wanted to go through those in more detail. As you can see, on the first page which is this, (holds up page). So, that has the first quarter of 2015 Kansas Medicaid Antipsychotic Prescribing at the top. We have the number of unique members within the categories of adults greater than or equal to 18 on three or more antipsychotics - greater than 60 days. Children less than 18 on two or more antipsychotics greater than 60	

	days. Children on at least one atypical antipsychotic at less than six, and then the same category but seven to thirteen years of age. And we broke it out in script count by practitioner and also by the number of providers that prescribe antipsychotics to those members. Dr. Adma: What is the denominator? So, which means, what is the total number of, I guess, members in all of the Kansas Medicaid population. Sec. Mosier: Right. And, that's on this page. So, if you go to the next page, so the total population is the 290,897. Dr. Larson: That would be for under 18 and then overall I think we are currently at about 425,000. Dr. Adma: So this is under 18 is 451 plus 284 plus 2,152 unique members under 18. Dr. Larson: Under 18, would be 290,000. Sec. Mosier: No. He was adding over here. Dr. Adma: Yes. So that is the denominator. Right, 290,000. What is the numerator? If we add the under 18 would be essentially 451 plus 284 plus 2,152. Right? Dr. Larson: 451 plus . . . . I guess I do not know where you are getting the other numbers, sorry. Dr. Melton: Are you adding . . . Dr. Adma: Yes. I am adding the unique members less than 18. Dr. Melton: Well, no; because there could be overlap there. Dr. Adma: There would be overlap, right? Dr. Melton: Right. Because we could have children on two or more antipsychotics is 451, but then . . . you really have to think of the first two lines as a kind of distinct group and then the last two lines are literally just our kids six or under and then the seven to thirteen. So, you could have, by necessity, your patients—your 451 patients—that are under 18, any of them that are thirteen and under, are going to fall in one of the bottom lines also. Dr. Adma: So even if you add the last two lines, it would be about 2,436 at about 2,500 prescriptions. Is that fair to say?	

Dr. Larson: That is the number of unique members. Not the number of prescriptions.

Dr. Adma: Yes. Unique members.

Dr. Larson: Correct.

Dr. Adma: Out of the 290,000? Right? Total prescriptions. . .

Dr. Larson: That's only up to age thirteen and the numbers that we gave you for the denominator are up to 17.

Dr. Adma: Up to 17. So you need to add the 451 then?

Dr. Larson: I think some of it we'll answer on the next graph that we will look at. We have it broken down more by rates of the total population.

Dr. Adma: Ok.

Sec. Mosier: So we have at the top the national rates. The most recent ones that we found were the 2009 for Medicaid specific being 8.9 percent for all psychotropics. And for Kansas for 2014, for youth less than 17 years of age, we have 9.1 percent of the population on any category of psychotropic. And then you can see that we've broken it down by category of drug. But then as you look down, just the ADHD, antidepressants, antipsychotics, antianxiety and anticonvulsives. Then when we get to the three drugs from any category, you see that the denominator changes for the total population looking at three drugs from any category, four drugs from any category. So that is where the number of individuals, the number of unique members that are apsychotropic. Does that make sense? So if you look back up on the all psychotropics line, the number of unique members is 26,493. And so then when we do the three drugs from any category, that's the population that we're looking at. So you can see that almost 4,000 around three drugs; 2,000 on four drugs; and again almost 2,000 on five or more drugs from any category.

Dr. Adma: One thing I wanted to please understand the decision is...There are members, there are prescriptions; each member might have multiple prescriptions, right? Is it fair to say that about 2,900 league members—less than 18? Is that fair to say?

Dr. Larson: On the less than . . .

Dr. Adma: On the less than 18 years. Is it fair to say based on the numbers that you have?

	Dr. Larson: So, there are 290,000 approximately, members under the age of 18. Dr. Adma: And that is the total number? Dr. Larson: Yes. And, the unique number is 26,493 were on at least one prescription for a psychotropic during last year, which equates to the 9.1 percent. Dr. Adma: So that is 26,000 . . . Dr. Larson: 26,493. Dr. Adma: Ok. So that would be 1 percent of the population? Dr. Larson: 9.1 percent. Dr. Adma: 9.1 percent—almost 10 percent? Dr. Larson: Correct. That is if we just looked at if they had just one—at least one prescription. That does not mean that is for the whole year. It could have been just one and that is where we looked—starting to look within that population of 26,000 how many had multiple prescriptions. So this count of 3, 4, and 5, would not be counted if they had the same prescription more than once. It would actually have to be a different drug. So that would be at least three different drugs throughout the year we had 3,900 - under the age of 18 Dr. Klingler: Liane, so is that…like in my practice we will have a kid that fails Focalin. So we try Vyvanse. They have weight loss on Vyvanse. So, we go to Adderall. Even though they are only on one at a time, they would fall into that three or four category. Dr. Larson: Yes. In this particular one, yes. It could be. On the first graph that we showed, that was where it would have to be the same drug for more than 60 days. So that would—we did, they did look to see if that was concurrent use. So for instance, you know we had adults on three or more 176 of them within that—that was if they were on 3 or more antipsychotics at the same time for more than 60 days. Dr. Adma: And the data you are getting it is the 30 day post filled data . . . . Where are you getting this data from? Dr. Larson: So, the first one we received was from the encounter data from the MCOs. The second graph that we received is through the MCOs themselves. This data here is collected as encounter data at the state. That is why we went back and looked at 2014 and the first one, first quarter of 2015 to make sure that	

	everything that was closed out point in time so that we could take a look at all prescriptions that had been filled by then. Dr. Adma: Ok. Dr. Porter: One thing that we should probably spend a little time on is that we've got numbers, but what are we to make of them. You could say that the overall rate of 9.1 percent of adolescents compares fairly similarly to the 2009 national rate, but what is the difference overall? I don't know. I think there may have been some changes in the prescription rates in six years in children. I don't think they are lower nationally. I don't know. Dr. Adma: What does the national data look like? Dr. Larson: The closest thing . . . Ms. Cuba: I can give it to you. Dr. Larson: . . .that I could find nationally was from that 2009 information. Dr. Porter: What I mean, I think we are trying to craft intentional interventions to change peoples' behaviors, hopefully, in the aim of making people safe—our Medicaid recipients safer. I think we need to really figure out how these numbers apply to that goal. Sec. Mosier: I think to that point, when we look back and we did a similar study in 2008 and that was the rate for all psychotropics at that time was 9.0 percent. So, one of the things, you could look at that and say that's good because it is stable. On the other hand, I would say at that point in time the reason why the study was done was because of concerns about these very issues we are talking about and we haven't moved the needle at all, which is the way that I would say to look at it personally. Dr. Adma: Twenty years ago, if you look at the number of antidepressants that were prescribed versus today, a lot higher, right? Because the deduction is higher that the length of stay in the hospital is longer than now is. Sec. Mosier: Then on the back of that sheet we have additional information specifically looking at the six and under age group and three and under. So when we look at one prescription from one category for children less than or equal to six, you can see the information there in terms of the number of unique members prescribed a drug for the year 2014. So the atypical antipsychotics was 469 for one prescription and then when we go over to two or more drugs from the same category, we've got 83. Then when we go down to less than or equal to three, we've got 69 unique members on antipsychotic medications.	

Dr. Adma: One very important finding in this is 60 percent of prescriptions in our state are being prescribed by non-psychiatrists. 60 percent, that is a very interesting statistic. Is there a comparison?

Dr. Larson: I did not pull a comparison from other states. I do not know if the MCOs would have any information in terms of their other markets. But, no, we looked specifically within here in Kansas.

Dr. Adma: Ok.

Dr. Klingler: Liane, I have one other question, these are all outpatient prescriptions, not prescriptions or drugs given in the emergency rooms during that study, right?

Dr. Larson: These would be just prescriptions filled for outpatient.

Dr. Klingler: Just outpatient . . . that was my assumption. I just wanted to clarify.

Dr. Porter: In the very young category, small group, but the antianxiety, anticonvulsive drugs could be used for non-psychiatric purposes, have we screened those out?

Dr. Larson: Yes. We took any child with a seizure diagnosis or related and removed them from the sample.

Dr. Adma: Another challenge for kids is the number of providers or prescribers, right. So you have a number of children on more than one provider. Did you take the primary care and psychiatrist and the nurse practitioner and sometimes it might be the same practice but the prescriber might be different.

Dr. Larson: Yes. As far as I know, it was literally by the prescriber. So if you would have had a nurse practitioner and physician within the same practice it would have come up as more than one provider.

Dr. Adma: More than one provider. And my suspicion is that some of this might be related to the foster care population when they move and they have more than one provider at a time.

Sec. Mosier: So, any other questions right now on the data? This kind of gives you a picture of the magnitude of the problem and who we are trying to reach in terms of the changes that we make for patient's safety.

Dr. Porter: Dr. Mosier, I have to say I am less clear because I do not know what the reference is. I think it certainly has to be because it is human nature and in human family. There has to be instances where people are on too much medicine. That has to occur and I do not want that to happen, but I don't know that just looking at this numbers tell us that. Or tells us where the problem is at. Or what we should go after—just

	by the numbers. Because you said the magnitude of the problem and I see a percentage of psychotropics that is 9 percent in children but I really don't know what that means as far as that gives us a target per se. Sec. Mosier: Right. Well, part of what I am referring to is particularly when we look at numbers like the 69 children who are under four that are on antipsychotics. I think that would be one, wouldn't you agree, that you would be somewhat concerned about? Dr. Porter: Yeah. I would like to . . . I think that begs an explanation. I do not believe that anyone on the panel last time was able to quickly explain that particular one away last time and I certainly can't. Ms. Cuba: I have some reference data. Dr. Porter: Ok. Ms. Cuba: In 2008, your prevalence rate nationwide for all commercial American owned insurance is 5.5 to 6.7. Then for Medicaid it would be 8.9. Dr. Porter: Yeah. We have that one. Ms. Cuba: This is not nationwide. Dr. Larson: I think this was referencing the commercial insurance across the board nationwide is lower than the Medicaid population. Dr. Porter: But again, is there a conclusion to make about that? These are different population groups who have different rates of . . . Dr. Adma: Medicaid nationwide is about 8%. Ms. Cuba: About 8%. Dr. Adma: 8%. Dr. Moeller: Maybe the concern is that there is not a lot of evidence based medicine to support two or more antipsychotics in children less than six or just atypical except for like autistic or you know stuff like that. So that's what I think she may mean by magnitude is what evidence do we have for the multiple . . . like benzos, multiple this, you know. We might not have milestone markers like you know this is number we want to get to but just kind of evidence based. That's kind of how I look at it.	

	Dr. Klingler: Do we know, Liane, on the children under 3 how that prescribing practice breaks down? Dr. Larson: On that particular one, no. We only did the prescribing practice as it would be affected to the current criteria that has been proposed. This information that we gathered was during another data collection which we were doing to look at foster care kids as well. I had to compile information from different sources so, no, we were not able to break that down by provider. Sec. Mosier: Do any of the MCOs have any information on this? Ms. Todd: I was going to say that on the large chart, I know this doesn't go down to the 3 year olds, but we have less than six year olds. And it is broken down by provider types and it is pretty detailed. Dr. Adma: So less than six in Amerigroup population who are on . . . . Dr. Larson: Less than six year olds. So on this chart here, she is asking about less than 3—if we have it broken down by provider. But we do have it for less than six years old. So whether we can make the assumption that it would follow the same type of prescribing patterns or not, we do not know. But we do have it for the less than six population, and then again it shows that 42 percent are with psychiatrist and then the rest of the 60 percent of that population are not being prescribed by a psychiatrist. Dr. Shoyinka: May I make a comment? My colleagues on the panel, I am a psychiatrist in practice as well and you are all excellent psychiatrists and providers. Otherwise, you would not be on this board. What I would like to do is ask us to consider this issue from maybe a broader perspective. Two things to keep in mind. Before coming to this position, I worked on a multi-state collaborative, where we focused on this issue in many states and so we are focusing on Kansas right now. But I do want to underscore that this is a national concern as you all know and there are good reasons that this is a national concern. The rates . . . the prevalence of this prescribing, to this population especially, this vulnerable population, has gone up steadily over time. There was a recent study—I was trying to find the reference just now—but just a few weeks ago that study came out—that talked about the same concern. What we really are wanting to sort of accomplish is looking at this issue from a public health stand point. It is easy as a provider to sort of fall into this same category and focus on our own population and our own practice of what we are doing. By and large, generally I think we would all say we are doing the right thing. But just keep in mind that you are the exception and not the rule. What we've seen from our data, is that –I think we will be sharing some of this data as we go along—is that the care and sort of attention that you give to prescribing these medications is not done evenly across the board. So, I really just wanted to broaden the scope of the discussion to move away from—or not to exclude—the idea that we are discussing a very vulnerable population. This is a public health issue of concern. Not just here in Kansas, but nationally. And that, yes, we do have data that shows that the right kind of monitoring is not necessarily being done.	

	Dr. Grinage: If I could just—as I am thinking about what you are saying there. You know actuarials are great and good for red flags—raise red flags to look at. But I don't know what the . . . for me it comes down to an issue of standard of care and then drilling down to each of those particular cases. You know I don't know that . . . I have a little trouble with anyone 3 years or younger being prescribed anything, but I am a forensic guy so I think anything medical malpractice issues. I am not a child psychiatrist. So I think a part of this is: Ok, how red is this flag; and then what is the standard of care is kind of my question and that is where I turn to my colleagues for the children—for the child issues as to how red is this flag. Is this a real concern? Because if it is a standard of care issue for anyone under three to be prescribed, you got a lot of cases there that need to be addressed. But I don't know if all of them are meeting a particular standard of care in the field—then they are meeting a standard of care. Dr. Esslinger: One thing, John Esslinger, with United, we wanted to add to what Dr. Shoyinka just said. We are making an assumption that all of you are good examples—very good examples of good prescribers and experts in your field. And when we look at some of the things that raised flags for us; for example, members taking—patients taking three or more antipsychotics, there were a total of none of you that had prescribed in that fashion. None of you on the panel. Similarly, for members less than 18 years of age taking two or more antipsychotics, there are a total of just eight patients for the entire panel. Two other data points, children less than six years of age who are prescribed at least one atypical, total of four patients among six doctors on the panel. And finally, ages seven to thirteen years of age that are prescribed at least one atypical—I am sorry, ages eight to thirteen on an antipsychotic a total of 38 members. So to the extent that you would reflect a benchmark of practice, those numbers are extremely tiny compared to what you heard earlier about how many patients are on these meds. Dr. Grinage: Was that information given in the last meeting? Dr. Esslinger: We would gather this from our claims information. Dr. Grinage: Ok. From the Medicaid? Dr. Esslinger: For the last twelve months. Dr. Grinage: Ok. Dr. Adma: I think both of what you said is very good points. I think, I am glad that you stood up and you said, hey, we need to take this . . . we have the same thing in our heart. We are not here to, you know, to say something that does not make sense. We want to take the greater good. At the same time, any change comes with price and we really want to make sure that people on this committee, it might take a little time, but we want to get it right. We do not want to do it so fast that we look back and then say 'what did we do?'. We want to make sure—we want to balance the book is what we are saying. This is not a new	

problem. This has been going on for some time and I am glad that we are shedding light on the problem. We want to fix the problem in the right way.

Dr. Mack: Even if we reduce it down into some very basic safety concerns. Like take antipsychotics for example, basic lab monitoring is not being done. If you look at the data, people are not screening for lipids or for blood glucose or for A1C. And, that is just a very basic thing that we would expect. I am sure that people on the panel are doing this, but the people out in practice are not doing this in general if you look at the data. And that is just a very basic public health safety concern that we would want to look at and focus on when we look at these things independent of the percentages of Kansas versus national data or things like that. And those are, in general, are not being done.

Dr. Grinage: Those are the type of standard of care practice that I am talking about. You know, I guess the question is what is the scope of this particular committee and how far do you drill it down? I mean, I think it's nice to raise a red flag and look at everyone's prescription practice, that data that you have. I've got a whole population of VA patients that you haven't seen; that are on two antipsychotics and need to be to keep them out of the hospital. So, what I'm saying is actuarials are good to raise the flag but there are, but for me, I guess, and I'm more concerned with the child issues, because that, to me, seems concerning, you know, where do you draw the line? I mean, what is the standard here? I think it's excellent that you take a look at this and you say only 42% of psychiatrists are prescribing to children under six. I mean, that may lead to a recommendation that we need to make. But I guess my concern is… there is, you know, you can't just use the actuarials to say that this is what's happening. You have to take a look at it as good information and know that there's some standard of care processes that aren't being met.

Dr. Porter: I would second that. I would hate to ever try to correct a forensic psychiatrist that would correct me back, but I do think when it comes to the metabolic monitoring that's been recommended for atypical antipsychotic medications that our psychiatric community as fallen short of doing that as much as we've been recommended. The numbers that I've seen would indicate we've gone from about zero ten years ago, we didn't even have scales in our offices, to something, thirty to forty percent, maybe not that high by your smile.

Dr. Mack: It's getting there.

Dr. Porter: So what I mean standard of care is what I'm meaning as far as meeting those particular guidelines, and getting the exact numbers. Especially when it comes to waist circumference, but certainly some of the other monitoring is just nationally not being done as much as APA and the American Diabetes Association recommend. I do think that something like this, reminders, and for most of us it's a reminder thing. We're busy; our EHRs are not set up to remind us to do it, I'm sorry to say. You just have to basically remember to do it and keep it in your mind when it might be due and it falls by the wayside. And I think there is a good chance, on that particular issue, attention to the matter. Nagging by an outside agency,

	be it DUR or directly from the MCOs would be good for patients, good for everybody. Dr. Shoyinka: And I think that speaks to that. In just conceptually thinking about the purpose of the board, of this committee, that's really what it's about. That's exactly what we said. How do we raise the standard of care across the board, across the state, and do so hopefully in a minimally invasive way. Dr. Moeller: And I think, well, that the guidelines they've proposed all have a backup mechanism. I know that's one of the main concerns is, you know, patients missing their meds and we don't want that to happen. But there's so many, that we change things from 30 days to 60 days, seems like there's a lot of doable stuff. We're thinking about the patient but we're also, you know, taking another look at it as a prescriber. Sec. Mosier: Dr. Grinage, to go back to, remember when we had the meetings leading up to the decision that the legislature made to move forward with this committee, is that we talked about the fact that there were safety issues. And that we understand with the prescribing practices though a lot, if anything, really in children in psychiatry is going to be off label, or most of that's going to be off label, so we wanted to have a wide area so that there wouldn't be that hindering of prescribing. But then it's to really look at those egregious practices on the margins and bring that in and actually create some bumpers, if you will, that can help with prescribing practices for those that aren't as experienced as all the people at this table in terms of prescribing, to really bring that safety forward. The other piece that we were looking at, as you saw with the numbers, we also realize there is an administrative burden. Safety is primary in this and then we also want to look at how do we balance this so that there's minimal administrative burden to the provider, so that we're maximizing the safety for our children. And then we've also talked about the elderly in some of these examples. But then we've also got; we're not keeping you from seeing more patients, that I don't want to see this where it's 'I have to see two people less a day' or something like that. But when you look at the volume here too, I don't think that the volumes would lead to a significant administrative burden. Dr. Porter: Dr. Mosier, when we looked at our unique members, it kind of gives us an idea of how wide a net we're casting. And where we are on the bell curve. We just have one of the first four that kind of stands out volume wise, and that's the one atypical age seven to thirteen. You know 176 adults on 3 or more atypicals that's a very small number, whoever, not that their not important, but the burden, admin burden, of managing whatever we do is minimal. I don't know how many, I guess, I see the percentage that's prescribed by psychiatrists; I don't know how many child psychiatrists there are in the State, off hand, but let's say there's 100? I don't know; is that rough? Dr. Adma: Less. Dr. Klingler: Maybe 20. Dr. Adma: Much less.	

Dr. Klingler: I would say 20 as a good guess, maybe.

Dr. Porter: However many there are, let's say 50 just for math purposes. And they've got half of these. So they have 40 percent; so they've got 1,000 of these unique members a month. What did we say, 50 psychiatrists, so they have 40 each? Is that right? Did I do that right? Probably should have used pen and paper. But that does start getting into, depending on the process, and if the process is similar to what my child psychology colleagues are experiencing with the dose optimization process, which is a different issue, but is an example of a prior auth process, they will have to cancel an hour per every one of these reviews. I think so, as I mentioned last time when we get back to it, I think we should look at the process and seeing how intrusive we want to make it. And then we also might want to look and see if that is a little broad of a net.

Dr. Larson: Can I just say one thing on that? Just on the age group, the criteria as it is proposed now, that doesn't necessarily mean that it would create that administrative burden, it's the way we have it currently is that it's just a certain diagnosis, and that they have to be receiving the proper screening. It's not that it has to be written by a psychiatrist. Those particular numbers would not equate to that many PAs.

Dr. Mosier: I think too, other things as related to the law that was passed, is that anybody on a stable chronic regimen is grandfathered, so you have to take those numbers out as well. So we're talking about new prescriptions, either somebody new to the program getting new prescriptions, or individuals who are getting new medicines that are already within the program. So that number becomes smaller.

Dr. Larson: Yes. We were just showing that in terms of how many in that age group that we have that would have to then meet the criteria of diagnosis. And the current way is the plasma glucose, lipid screening, weight, height, and waist circumference.

Dr. Melton: And we did it that way because they are, technically, FDA approved. A lot of them in that seven to thirteen age range.

Dr. Porter: Under ten.

Dr. Melton: As long as you've got a practitioner who understands that we are looking for correct diagnosis and then monitoring they could, technically, prescribe it. That's what we were looking for.

Dr. Esslinger: One thing that I'll say is that there certainly doesn't appear to be any disagreement about the safety concerns here. I understand the administrative concern. Frankly, it is a concern for managed care as well. It takes staff to take all that in to handle the requests, the reconsideration, the appeal, all that stuff. So it's certainly no free ride for the managed care organizations either. And as I think was said just a moment

	ago, we could put in place something that would grandfather certain patients who are stable and on an existing regiment, and those who have been approved or authorized, if we had a PA process in place this shouldn't be something we have to revisit every month, every quarter, probably once a year. And keep in mind that over 50 percent of the prescribing these atypicals is not done by you experts, it is done by primary care physicians. And they really need help and assistance, I think, in making sure that we are doing the right thing in terms of safety. Dr. Grinage: But I'm telling you that is not out of desire that is out of necessity. We don't have—when you have one psychiatrist in a community mental health facility for 20 counties in western Kansas it gets a little difficult. But, it is an issue. I don't have a quick answer. Dr. Esslinger: Two other data points, and they are on atypicals. So we have 192 patients, this is a year's worth of data this is just United; 192 patients that do not have a mental health diagnosis listed and they are on atypicals—192. And we got 29 percent of the 18 and overs that have no claims, zero claims for outpatient mental health visits. So as was mentioned I think by you, Ty, last time, you know medications is a critical part of therapy for these patients but so are counseling services. So I think that these need to be taken into consideration as well. Dr. Adma: So is that fair to say in those 192 patients, these are being prescribed by the primary care physicians who are not using a psychiatric code? Dr. Esslinger: All I know is that 192 of them do not have a mental health diagnosis listed. Dr. Porter: You would have a really hard time finding –if you were a physician or psychiatrist trying to bill for your work. You would have a very hard time not submitting a psychiatric diagnosis. Dr. Adma: That it is probably most likely a PCP . . . Ms. Murff: Just a little – the background on the data. We basically just looked at our members that are on atypical antipsychotics and then we just scrubbed through the medical claims to look for those claims for outpatient medical services. We also looked at the labs that Liane mentioned that are associated with antipsychotic therapy. And overall our population, eight percent have claims for those labs. And for our under 18, three percent have claims for those labs. And as Dr. Esslinger said, that is from January 2014 through March 2015. So we included that first quarter, we wanted to make sure that we had a broad sweep for time. So these are patients that had claims on—and that data was just members on one antipsychotic. We pulled the data for that. At least one, I should say. Dr. Moeller: Did you look at just a complete metabolic panel? Because that's just surprising. . .	

	Ms. Murff: Yes. We did CPT panels. Lipid profile, blood glucose. Yeah. We crossed walk with quite a list of CPT codes for that. Ms. Todd: Which is not necessarily surprising that you see that where patients are getting prescriptions filled but they are not –but we are not ensuring that they are getting those office visits and that they have the appropriate monitoring. Dr. Klinger: I guess the thing as a primary care physician that boggles my mind is these numbers of less than 3 year olds and I am no more equipped as a primary care physician to diagnosis psychiatric illness and prescribe. And if truly less than half are being diagnosed and prescribed by psychiatrists, that, to me, is something that really warrants looking at. I think 3 year olds behavior if you are not familiar with it and under the range of normal versus what might appear psychiatric is fairly—there is a lot of cross meshing there . . . to say the least. And that number of kids on antipsychotics just under three—and I guess if I was to look from my vantage point where the harm is, those are the kids that I would definitely want prescriptions supervised by a qualified mental health provider that is boarded in pediatric psychiatry. That population to me has a special place in my heart because of what I do, but is extremely vulnerable. And in looking at the number of prescriptions in that population, to me, is where I think there is probably a breakdown in services to children and families and in prescribing practices maybe the red flag as to where we need more services in those areas. I would also say your numbers have reassured me that I use appropriate psychiatrists because they all send lab recs for my patients to have labs drawn locally so . . . . But the under three, I think, in my opinion, deserves more scrutiny than some of the other categories. Dr. Grinage: I would even take it a step further and say you probably—it would behoove us to maybe look at child psychiatry standards of care. You do not have a developed liver yet. I don't know what these notices are, but if it is a practice, certainly off label, but there are a lot of off labels things that are indicated to prescribing antipsychotics in a child under three, I am unaware of that but if that's a practice—if that is a standard of care that people do prudent provider would do in a particular circumstances, but I think that is worse. I agree that is worse and that is the one that stuck out to me as we are looking at sort of the bell curve like we talked about with working around the edges that's a—I agree with you. Dr. Porter: I have questions since we have the panel I guess makeup changed to include our colleagues from the MCOs. You guys have good information and we are talking about making an intervention based on not giving a prescription. Let's say you can't give someone a prescription if they are not doing this. But what's to say you don't just directly question somebody when you see someone…You can say why on earth is this 3 year old on an antipsychotic instead of waiting to do all this and getting a prior auth. Is there a reason you can't just expect someone to explain that to you? In this case, being the guardians of the young people's health at least from your vantage point? Of course, the physician is the guardian in health too, but…	

	Dr. Esslinger: Well, I think to operationalize it, given that there are thousands of prescriptions, the intervention, if you want to call it that, has to occur at the point that the script is being filled. I think a retrospective look just doesn't work. The art of persuasion giving it some practice data and saying can you do better in the future so to speak. Dr. Grinage: How about a diagnosis? Dr. Esslinger: Well, in many UM practices include the things like if you are going to prescribe this drug our criteria is that you have to have one of these diagnosis. I mean that is the standard utilization management in pharmacies which is done, by the way, in 23 other Medicaid states. I mean this is—honestly Kansas is the exception right now in not having a process for this, in it's clearly it is a safety issue. Yes, I agree with Dr. Adma that you have to balance it against the administrative hassle. But I think if you look at the pattern of what prior auth has been. It has actually been going down, because again as I mentioned earlier, it is a substantial cost to the clients as well. We do not want to do it any more often than we need to. If we are seeing 90 percent approvals, we don't do prior auths on those anymore. So it can be a dynamic process, but I think given the safety and medical appropriateness or not that we are dealing with here, we are looking to collaborative work with you to assure that the right thing is done for the patients that we serve. Dr. Klingler: Can I ask a question about that comment. You said that 90 percent you no longer look at. Is that by provider or by patient? Could you clarify that? Dr. Esslinger: I will give you just a general example. I will outline the approach. I have been with a couple of clients over the last 15 years and periodically they will look and say, my gosh, we got an awful lot of people doing prior authorizations. How does it look? How often do we say no? How often do we say yes? How often do we overturn our decision? What's the volume? All those things are looked at. What's the cost to doing that? Prior "auth'ing" x, y, z surgery? Prior authorizing these certain medications? It is a fairly substantial detail analysis because like you we don't want to spend any more time than we need to in things that don't need to paid attention to. I hope that helps. Dr. Mosier: Dr. Porter, to your point, so we didn't add to the committee but we felt that we needed additional information for some of the questions that came up, certainly like prior auth practices. Each of the MCOs could, from both of the medical director and pharmacy director perspective, provide that information. So they're here for your information resource. Dr. Larson: And also on the pharmacy side of it, having PAs at the pharmacy is the first entry into it in terms of determining. The medical billing will come later but filling the script at the pharmacy, that the first time …correct me if I'm wrong but this is the first time that MCOs may know that the patients is getting 3 antipsychotics. So it would be stopping it at that point, before the patient fills that prescription and then	

	starts on the 3 antipsychotics. Because that's actually the first point of entry for the MCO to knowing that this has been prescribed to the patients. Dr. Adma: As point of reference, one of the things that we've done four years ago at KVC. Because nationally it's known that foster care kids are on a lot more psychotropic medication. So internally what we've done is created ways we can collect data on these kids. We've looked multi-state and what they are doing and within our population we manage 3000 kids. So, what we've done, we started collecting data and we actually not only have thresholds in terms of the dosages the kids are getting prescribed and stuff. Anytime, any kid in our system gets prescribed 3 or more antipsychotics for example. I automatically get a red flag and an email sent to me. Because once a month when the case manager go and sees these kids they get a medication history and they put it in the computer. The computer automatically sends me an email and I look at it and it will have the name of the doctor and I make a phone call and so on and so forth. Same thing, two or more antipsychotics for a period of time. And sometimes these things the nurse practitioner manages, some of them I do. And earlier, Ty pointed out, we have created systems within our system to see how we can tackle those issues. It is within our system that we can call the doctor and find out why they are doing what they are doing. And it has certainly helped me make that dialogue, and Dr. Shoyinka does that all the time with me when we are talking about patients. You have psychiatrists on your side that can review who are able to review these practices. Wouldn't it be a healthy relationship to develop? Use these data points as a starting point to say why can't we…We know who are the offenders, because you know who are the offenders, we may not. And say, could we at least take this as a first step to go to that primary care doc who writes all the time these 3 antipsychotics. Dr. Melton: That's a program that we've had for fee for service Medicaid for years prior to moving to KanCare. Where we would look at problematic prescribing patterns and we did it a lot in the mental health arena because we couldn't manage it through DUR. And we would actually send out a pharmacist in person to do academic detailing with those prescribers who had gotten the highest volume of letters. We'd go back six months later and look at follow up and our mental health topics consistently showed among the lowest rates of change over that six month period. So that was discouraging to us that even after sending out patient specific letters and then our toughest cases going out and meeting with them in person six months later we weren't really seeing change. Because there is nothing to impel them to really look at what they are doing and make changes. Dr. Adma: So that was more consultative rather than having any teeth on it. Dr. Grinage: I would just reiterate what Vishal said in that, I do think you need a hammer or some kind of enforcement but philosophically the difference is between putting up a bunch of barriers for all providers versus trusting providers and then going back and correcting. And I think, from a philosophical standpoint physicians respond better that way. You've just given evidence that that's not the particular case for those particular providers.	

	Dr. Porter: Having been to a few meetings and been in management for a while really I'll say physicians, it's probably people. If you want to change our behavior you throw a form at us or hit us in the wallet and we change our behaviors. The prior authorization process is a behavioral tool to get us to do something differently. It's a powerful tool. You may sense some negativity and paranoia; I'll tell you it's not from the time I get to talk to Dr. Shoyinka on the phone. That's a colleague and you have a reasonable conversation with him and come to a reasonable conclusion. But most of us have had a breadth of experience with prior authorization calls and prior authorization processes which have become very senseless and it's very frustrating because they get out of hand. I'm getting prior authorization requests for $4 generic medications. That company just spent more money on contacting me than the medicine costs, cash. And I'll talk to a colleague and I'll clearly explain everything and they'll just say, "Doesn't meet criteria… send an appeal". And so, that's what we're scared of. We are not scared of talking to a reasonable person and explaining to them. Or the flipside, one of us that doesn't have a reasonable explanation not being able to prescribe that medicine. This is a very powerful tool. I don't know how many states have let us in on the process and that's one thing that's going to slow it down a little bit. We've seen how badly it can go and how much it can interfere and how senseless a prior auth process can get. We do them all the time but I've never been asked to put my two cents in so I'm going to. Sec. Mosier: I think you make a good point, but I think, we're mixing, in a way, two issues and if we can deal with the administrative burden issue just up front, separately, then I think the safety issue will follow easily. Because I think we all have a lot of agreement on safety. And so if we look at the administrative burden piece, I think one thing that we've looked at in terms of other states, and even in the commercial space, is kind of this preferred provider status, if you will. So pretty much everyone here at the table is going to be in that status where you are in the preferred provider, where you aren't prior auth, you might describe how you do it in your commercial business or you've done it in other states, but it works very well. Then what we're looking at is, what takes out over time, there'll be just you really looking at a much smaller pool of providers and looking at their prescribing practices. Not the good prescribing practices that you practice would be in this preferred provider status. Do you want to describe how it occurs? Dr. Friedebach: Sure. I think to kind of level set where we're at. We have the same experience as United. When we looked at all the panel numbers, the number of prior authorizations that would be required are very, very, very low. So I think the scope of which you look at this prior authorization criteria, you invariably are going to look from your own perspective. But what we've found in practice was this is not where the opportunity lies. I'm sure that probably may or may not surprise you. And that some place where preferred provider status could possibly be of assistance. When we look at utilization, and so, most of us agree that some of these findings are concerning. The fact that these patients were on medications; they haven't had lab monitoring. And that's very, very low. The fact where we have children on two or more antipsychotics; that's one where we found very few instances as you can see here. Adults on 3 or more, these are issues that do we have a significant safety impact for our patient, if it's not used in a specific	

	scenario. When we see a provider that may have a consistent tendency to prescribe this way; there's an opportunity to talk to them about ways that they could change. On the other side of that, if we find a provider who, across the board, Dr. Shoyinka looks at the pattern; we look at the monitoring and we see that a consistent standard of care. In part, as defined by this committee, is being met, is an opportunity to say – hey we're going to look at this on the back end. We're going to make sure that you continue to prescribe in a way that's consistent with the diagnosis, that the monitoring is taking place, that you're preventing poly-pharmacy when you can. We will look at it on the back end but lift some of those prior authorization requirements. So we have the opportunity to do that. There's a lot of discussion about how do we define that. Is that something that is defined by provider type? Is it defined by age group that you serve? But probably the most appropriate thing is to look at prescribing practice. See that gold standard of care and then recognize those providers as having that. I think one of the things when I look at this and look at the population, and it's not lost on me that the idea of the one atypical antipsychotic in children is a pretty big population, but we also know from the data that children are less likely to get the screening they need. We would suspect that the metabolic outcome for them are potentially going to be worse. And for the foster care population in particular, their advocates may not be as adept at saying --hey, I care very much about their potential of developing diabetes; I care very much about the obesity they are struggling with. We understand and we see it and we deal with it every day. Permanence in a home is so important and adding the medication if that keeps somebody in a stable environment, we really want that to take place. We understand the pressures that are out there. And like I said, for these providers on this panel, the opportunity to look at your prescribing practice, as we have, and see that you have a hand full of patients that have fallen into this category, we've looked at it critically, we very much agree with your assessment and putting you into preferred provider status is something that we certainly could do. And I think it's just a matter of, to speak to as well, Sunflower has been doing outreach to providers. Much in line with what the State has been doing or was doing, for two years now. And so we have that outreach, but it's a matter of all those things that are difficult to do, that monitoring, getting the patients the supportive therapies. And when I think about the 3 year old, for example. Not only the therapy for the 3 year old, but for their family. You know. So the idea that we give a 3 year old a psychotropic medication, and give them no support to succeed on that medicine, that's where we kind of have to look at our population basis. And I think what we will find, we have found, that there are a number of providers who are very much practicing the standard of care that we'd all be proud of and there are a small group of providers that are struggling to meet that. And most likely it's because of professional isolation. And because of them being in very dire circumstances with the very challenging cases. But that's kind of a long winded description of what a preferred provider could look like. And we've talked about how could we bring this together as a group and then talk to this committee. And as Dr. Shoyinka said, I think that's the committees opportunity here is to define the standard of care from the lens of your own practice. What is something that should be a red flag? These are red flags to us. Do you agree? And so, yeah, I think we can do that with the preferred provider status as well. Dr. Adma: One more thing to add to the discussion to the lab, metabolic lab, is a lot of times, say for	

	example foster care; they may not be doing it because they might change the placement. Then there you go, they don't have a PCP, they don't have a psychiatrist who is going to order the work, So it's a very, very dicey situation. So if they don't have those labs done, are we saying they can't get their prescription refilled? Are we going to maybe give some leeway; saying again this is your first warning, within the next 30 days, something like that. Dr. Friedebach: I think that case in particular is something to highlight. Because it's a fairly decent size population. It's an ambitious goal. Nationally, we are all struggling with this kind of monitoring for this patient population for a lot of different reasons. But it's a worthy goal, particularly in our kids. I think our willingness to put overrides in has been pretty consistent as far as grandfathering; as far as overriding for emergencies; overriding for extenuating circumstances. So we want to be very active in that. As far as this population is concerned, the prior authorization request for that is essentially through the portal or a paper process where you would indicate the diagnosis. You'd put what you were requesting essentially and then potentially attest to the fact that they've had that monitoring. So when you think about that group in particular, that process should be much faster than what you have experienced in dose optimization. Because in dose optimization, what you're basically saying is, we're kind of going away from what you may think of as an optimal dose because of these reasons. And then the pediatric population, we kind of talked about that. But for the monitoring, it really is very much: they've got this diagnosis-check; they've had their monitoring-check; and then the medications. I think it's a bigger population, but I think it'll be a pretty quick authorization. We would certainly endeavor for that to be the case. And I can guarantee you that we don't want any of our foster care kids to go off of medication that's critical for them to succeed. I think there are safeguards in that. Ms. Cobb: I also think, in the heat of the moment, or often times when these medications are prescribed, there's so much going on, that a long term effect of a metabolic or something down the road tends to get pushed aside, because in this moment, that's not the problem at hand. So something to move these things to the forefront of the providers mind when they prescribe would probably be helpful. Because very much that's something that's 'ok, we'll get to this down the road' with the best of intentions, and at times it just doesn't happen. Dr. Esslinger: I wanted to get back to something Dr. Porter said a while ago. A couple things, actually. One was about the EMR; wouldn't it be great if there would be reminders and ticklers and all those things and that's actually a big helpful tool that apparently doesn't exist in all that regularity today, but you also said that without some sort of a 'stick' so to speak, be it a financial or a prior auth, the right thing doesn't always get to happen as Dr. Adma is hoping. I'll give one more example of that and then have a suggestion. Elective pre-term delivery. This is in the obstetric world. That's delivery before 36 weeks. Often for the convenience of the obstetrician or the Mom who's tired of being pregnant. Was a big, big national problem. And there was a national campaign among a variety of organizations and managed care to put in place what is called hard stop policies. What that meant was, an obstetrician who scheduled a delivery; an elective	

	delivery, say at 35 weeks, could not get that done unless certain criteria were met, and if they wanted to, they could discuss it with the Chief of OB for that hospital. C-section rates in those hospitals fell dramatically with those evidence based policies in place. All kinds of educational things had been done before and none of them worked. That, and my one other comment is that typically once you right size this, the need for prior auth just goes down, it just does. What I am going to suggest is that, we think about ways, we are fortunate in ways the State has seen fit to have a uniform approach to drug lists and things. Maybe we can have a uniform approach among the three MCOs to gold carding, that kind of preferential good prescriber status or whatever you want to call it. And then we can get to the part that I think is going to be the easiest, and that is consensus of reaching standards of care and that sort of thing. Dr. Porter: You know, I think…I appreciate the comments made by panel members and other people that perceive us doing ok at our job. I actually don't mind. I have patients in my population that I've gotten to a place that their prescription pattern looks odd and I don't mind that I should be required to explain that. It should be in my chart. I think, again, some increased focus on documentation would do three things. One, it'd make us think more. You have to think before you write. Second, we have to document, which is everything, really. And I would think that would also keep some of the more unsafe practices from happening. I just, I think, just to add, go from that, one other thing, we are talking about safety. I go back to something I mentioned last time, on the first category, the 3 antipsychotics is 3 antipsychotics. So much of the else we are looking at is the atypicals. I have this fear and concern that whoever these providers are that are giving children an antipsychotic, a 3 year old, that if we monitor them by monitoring atypicals than for whatever reason they are doing this, give them hell. Even though I was saying I didn't want to cast a broad net, I think if we are going to say antipsychotics, then we should to say antipsychotics. There's nothing, by any means, to say that typicals are safer in children. They're much more neurotoxic as a matter of fact. Maybe not metabolic dangerous. Dr. Moeller: I worry about that too. I was thinking about that last time. People will switch. Dr. Larson: We can look at that when we get to the criteria. Dr. Porter: Prior auth will make you change. I was talking to a doctor about the dose optimization thing. So he won't send in two 1mg Vyvanse prescriptions anymore, he doesn't want to do the prior auth. He'll tell them to break the 2mg in half, which is not how the pill is designed. I don't know if that's a terrible thing, but you get people doing whatever they can to avoid the prior auth, but it may not always be a move toward safety. Dr. Shoyinka: I'm glad you brought that up, Dr. Porter, because I've been looking at the numbers on ADHE meds in kids under 3; you have to be six years old to meet that diagnosis. I don't feel any more confident in this than the discussion we've been having about antipsychotics. But I think you are absolutely right.	

	Dr. Klingler: But if you look at the evidence based medicine for kids diagnosed with ADHD, in that age group, the number one method of care is parental counseling and behavioral therapy for the parent is the proxy for the child. And I've been in numerous CMEs, with presenters from different parts of the county, and that's not a unique concept, it's the standard of care as the behavioral parenting is where you go, not automatically to the stimulant drug or a non-stimulant drug. In that category, but at the same time, I think we have such a lack of providers and a lack of education to prescribers sometimes that those things get lost. I live in a fairly, I would like to think that Riley county is fairly cosmopolitan, even though it technically is rural, we have no one that does behavioral parenting in Riley county. So, you know, I can't imagine somebody up in Clay Center or out in western Kansas trying to find those resources. So, I think, as I'm listening to this discussion, the drugs, I mean there's some issues, but I think our access to appropriate care for a lot of people is a broader issue that's beyond the scope of this committee. But as MCOs, maybe your assistance in trying to find those mechanisms to get the kids the appropriate help. Dr. Esslinger: We appreciate that. And we realize it's out of the scope for the purpose of this committee, but we have worked collaboratively with the State and have a very intense interest in extending telemedicine, not only between doctor remotely and patient but also a consultative basis between primary care doctors, such as yourself, and specialists. That was brought to us by a couple of our primary care docs that have QHCs and they say: "hey, I want it for me too". Which I would think would be great. Because they're to see the patients more often than the psychiatrists are. Dr. Shoyinka: They often don't need more than that, one or two. The consultations, just to get it right. Dr. Porter: I guess if we were to pare down our mission, we have one mission is to identify the at risk categories. Each one of them has its own controversies, but I know there's more, we've added the 3 benzos on, I believe there's more for the committee down the way. Sec. Mosier: Right. Dr. Porter: So maybe it would be somewhat of a good way to divide the task, if we simply, if I did my best to set aside the process concerns I have. And we decide as a group to look at the categories themselves and agree if we think there's reason for concern with each category. And then spend as much time as we need, agree on what we can there, and then spend time talking on what needs to be done. What process would be best?	
III. Old Business A. Minutes Review and Approval	Sec. Mosier: That sounds good. I'd like to take the prerogative of moving to III. B, and skip A for now in the interest of time. We can do the minutes next time as they are about 40 pages long…	September 1, 2015 Meeting Minutes were tabled.

III. Old Business B. Prior Authorization Criteria 3. Antipsychotic Dosing Limits – Review proposed daily dose limits for patients prescribed antipsychotic drugs.	Sec. Mosier: …And go directly to the Antipsychotic Dosing Limits. So Liane, do you want to review the changes we made based on last times discussion? Dr. Larson: So first we have up is the Antipsychotic Dosing Limits which is simply putting a daily limit, daily max dose on those drugs listed. The changes that we made were highlighted in red from the discussion last time. • Doses exceeding those listed in Table 1 will require prior authorization Prior authorization will require a peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval <u>Clinical Public Comment:</u> - No requests were received. <u>Committee Discussion:</u> Dr. Grinage: Did you get my email? My email about those. Because I disagree with 1, 2, 3, 4, 5 of these which I testify as being standards of care. To me it's just a black and white, yes or no, sort of thing. Dr. Larson: And these are just the ones, last time what we showed was the various states that have applied these limits. And so we just, for these as suggested for the limits, what we had based on FDA maximum doses and what have been applied by other states. These were just the recommendations, open for discussions. Dr. Porter: I brought your comment to last meeting. The two things that moved on were, what Liane said, that they showed what all the other states considered maximum. And also the number of unique members that this affected was 176. I kind of let it go, I hear your point, you've testified. Dr. Grinage: My point is would basically be, you know, it's, the prior authorization, I know, it's a, you know, there's a reason for it, and certainly doesn't hurt except for it takes time and makes physicians very frustrated. I routinely see in my colleagues, multiple colleagues, it doesn't matter to me how many the number, as a purist I'm just saying, it's not uncommon to use 60mg Aripiprazole, it's not uncommon to use 1,500mg of Seroquel, I've routinely used 320mg of Ziprasidone in schizophrenics, schizoaffective and bipolar populations. Why? Because it works. I don't use over 16mg of Risperidone. You know why? Because you don't need that much. I think when you look at the history of the atypical antipsychotics and how they were developed Risperidone was over dosed, everything else was under dosed. But if they are FDA approved, it's going to cost way too much money to change that. And that's just a clinical, professional opinion. I don't know if it's worth changing that or not, but that would be my opinion. Dr. Melton: So I guess our thoughts around that was, we don't disagree, but for specific cases, that may be appropriate therapy. But what we are asking for with the prior authorization is that we at least give a chance	Abilify, Seroquel, Geodon, Olanzapine, and Ziprasidone were removed from the table and will be discussed at a later date. With that change, Dr. Adma moved the criteria be accepted. Dr. Klingler seconded the motion. The criteria were approved unanimously.

	for a peer review with a psychiatrist for those kinds of cases. So we would hope that your 60mg Abilify patients are more of an exception than a rule. Dr. Grinage: But they're not. They're not when you're dealing with the schizoaffective and schizophrenic populations. And that's my point. Certainly 90mg should be, in my opinion. And I have used 90mg of Aripiprazole, but I routinely see, pretty commonly seen, and I laid out what I felt were pretty straight forward standards of care on these. And it's just, you know, and I guess you can ask 100 different psychiatrists and get 100 different opinions. That's where I'm at. Dr. Melton: And that's kind of where the numbers came into play. Looking at what's reasonable. Dr. Grinage: I do have a problem, a little bit of a problem where some of these, where a lot of these are the FDA label and a lot of them are not. Why choose that? Why choose 1,200 of Quetiapine, why not make it 800? Dr. Larson: This is what we showed last time, so I tried to look at surrounding Medicaid states as well as others that I was able get information on and these are the current limits set in place by those states, so that did come into the discussion last time. Dr. Grinage: States don't prescribe medication. Dr. Adma: What you're talking about Brad, your primary practice is VA? Dr. Grinage: Yeah, and I have a private practice too. Dr. Shoyinka: Dr. Grinage...outside of your practice, your specific sort of niche population and you've talked about being a forensic psychiatrist. Dr. Grinage: I do have a forensic practice. Dr. Shoyinka: Outside of that population, how common would you say those dose equivalents would be? Outside of that highly specific, high needs population? Dr. Grinage: Outside the schizoaffective, schizophrenic community mental health patients that are usually on Medicaid, outside of that population? Dr. Shoyinka: Yes. Dr. Grinage: I don't know, that's white collar practice and I wouldn't know. I would assume it would be	

	less. Dr. Ellermeier: To the discussion earlier, I think we've got to take this discussion up to a higher level and not just think about where we see things but really, generally, would you be comfortable with a primary care physician prescribing Abilify 60mg to a patient without a reasonable explanation for that. I think that's what they are asking for is just a reasonable explanation as to why. These doses cover the majority of patients, the majority of cases. Aside from some specific cases where they are seeing a specialist, but I don't think anybody would be comfortable with a primary care provider without some reasonable explanation prescribing above that. Dr. Porter: I just want to revisit. When you set a dosing limit, because again doctors don't want to do prior authorizations, nobody does, what you actually are promoting in the most ill population is polypharmacy. Dr. Grinage: That is the biggest issue that I have. Dr. Porter: If 240mg of Geodon is ok, but 320mg gets me on the phone tag, then I'm going to be more likely… Dr. Grinage: And that's where you see patient safety go down. Dr. Porter: …to try adding quetiapine to it, or something else. And that may be ok but I'm just saying that the dosing limits with the most ill patient lend to polypharmacy decisions and that's just a fact. Dr. Larson: So that's why I think we tried to merge and have that multiple antipsychotic use policy in as well. Dr. Shoyinka: To your earlier point Liane, when we looked at this internally and discussed these limits. These were considered just a starting point for discussion. That's again what we are here for…what's reasonable considering the broader picture of everybody who's prescribing these medications. What would we feel is safe and comfortable? Dr. Grinage: I think it's a very good point that's brought up if you have people who are non-psychiatrists or non-specialists prescribing. And this gets back into the whole process issues that we were talking about before. I don't like the term preferred provider, I prefer that you guys develop a non-preferred provider. So everyone gets to do what they want until you identify rather than put up barriers. It's a matter of semantics but I think it really has a powerful impact on the day to day workings, what changes behavior and how people may try to manipulate and not have to do things because there are all these barriers put up. I would have a problem with a primary care provider prescribing 30mg of Aripiprazole in a severely psychotic	

	schizophrenic patient. So maybe we need to talk about hard stop type things. You have to be aware of resources available in certain areas but I would be concerned with that as well. But I have a problem laying a blanket barrier over everyone and then you have to prove yourself, versus something that happens routinely in the patients and with the colleagues that I see. And my VA patient population, Bill knows that, if they had to do prior authorization on MICCUM clinic patients that would be crazy. Dr. Mack: But I also think that the VA eastern Kansas, that is one of the sickest populations in the region, it's the tertiary referral center for the region. I remember internally when we were looking at our data when I worked there and you and I both worked on that data set together. It was pretty much the highest amount of psychosis and highest amount of antipsychotic use in the nation. We were trying to look at how we were going to get that down, so It's a very, very sick population. I think a combination of Menningers being here and us being the tertiary referral center just a large amount of psychotic sick individuals ended up in this area. A very, very sick population so it was very routine to have patients on 1600mg of Seroquel. I don't know if that plays well to the state population Dr. Esslinger: I would urge the committee, if you can demonstrate that you've got a pretty unique, extreme population that we have a mechanism to deal with practices like that. Rather than take the whole policy and take what I consider to still be shocking numbers about 8%getting labs, 29% not having any outpatient mental health visits and another chunk not having a mental health diagnosis. I think that, first do no harm, that's what comes to mind. I understand that no one disagrees with that here and I also understand that some folks may have a practice that's way off here... Dr. Grinage: I don't think it is. And correct me if I'm wrong because I would like to know that. Dr. Porter: My view of the mental health center population I've seen is… I keep talking about prior auth. What you really also don't want is a patient leaving your office, needing their symptoms addressed, go to the pharmacy, and not get the medicine. That's the bigger problem. And for that reason, it happens for a variety of reasons too often. Regardless of what the MCOs here are doing or Kansas Medicaid has in the past, Medicare part D plans are a big part of treatment of severely mentally ill people and they all have a variety of policies about what they'll approve. Many of them will not approve above the PDR dosing. In which case, again, I think there is a hesitancy to go above the dose, above the PDR dose which leads to people adding two or more antipsychotics. We are only looking at the Medicaid population, not actually the number of patients in the mental health center. So I think it's a tradeoff. And my personal belief is it would be better, if it showed efficacy, to be on a super dose of a single agent rather than smidges of several. Dr. Shoyinka: I would agree with that. The other question that comes to mind is to what extent Clozapine is being used in those populations. I treat the same kind of population in my practice. In the last year I've actually moved many of my patients on high doses or multiple agents to clozapine. It works for a lot of	

	people, it doesn't work for everyone. And frankly, that's one of the opportunities that we see with all of this discussion. I think the question should be asked, to what extent is that drug being used. Dr. Grinage: I know the state hospital population, because I've consulted in the state hospital population and I'd like to see the data because these are routine dosing schedules of people who leave the state hospital and then they'll go back out into the community and I guess you can require everyone to do a prior auth on this. To me, it makes no difference if you put it at PDR because you're still going to have to request the increased doses. Dr. Mack: I think one of the benefits of having everybody here at the table is that you've got the potential to stratify this in terms of things that are not grey area and things that are grey area I think everybody pretty much agrees that kids under 3 years old, that should probably be looked at. There is very little evidence that using 3 plus antipsychotics in people, that's something that should probably be looked at. If people are concerned that going above FDA dosage maximum is going make you decide to add a second medication rather than go through the prior auth process then that's something that this committee could workshop to try and find an answer for that. Try and work with the MCOs to say that we propose that you do this to make that process easier so that I can use that higher dose without having to be on the phone for 20 minutes. There is probably an easy way we could solve that. Dr. Porter: We're talking about academic decisions and I'm not in academics anymore. I don't know what the actual research shows, what would be the best choice, two antipsychotics or a lot of an extra of one. All I'll do is see a patient and I'll talk with them and we'll agree on a course of action and if it helps, that's what we go with. This is an important decision because you keep the levels low you're promoting polypharmacy if you let them higher than your promoting high, unproven doses of a single agent. And I'm not sure where the science lies on that. Dr. Mack: It's best to use one, ok to use two, but there is very limited data for three. Dr. Porter: The question I have is, my intuition, if there weren't dosing limits I would probably go higher single agent rather than add a second. Dr. Mack: And clinically that's still preferred. If we go by stand care and by most experts, that is still the preferred method. Dr. Grinage: You're right there is not a lot of empirical data on 1500 mg of quetiapine because no one is going to do that study. Dr. Mack: True but we could workshop that as a group and make that less onerous on the practicing physicians to get prior auth on that. So they don't have to add a second one. There are mechanisms that we	

	can come up with as a group. Dr. Adma: My take on this whole issue about the doses again goes back to when we got started on this topic, we're not talking about individual practices. We are talking about practices across the state as Nicole has pointed out, from a public safety standpoint. Is it reasonable, because you are seeing 60% prescribed by non-psychiatrists. Sec. Mosier: So you said there were five of these that you had concerns about the dosing that you might want to go above but the other eight you're ok with. How about I would recommend to make a motion to move forward with the eight and then we can have further discussion about potential processes. There has been a lot of good discussion, a lot of things to think about, there are a lot of different ways to tackle the other five, potentially. Dr. Grinage: Sure Sec. Mosier: So I need to know the other two; I know Abilify, Seroquel, Geodon… Dr. Grinage: There are two quetiapine's, olanzapine, and ziprasidone. Dr. Moeller: I did want to comment because you were talking about what other practices do. So, I'm not at the VA but I am at an academic medical center, acute care. We see high rates of schizophrenia, very common. I was just going to say that I haven't seen an Abilify 60mg in years. Now quetiapine, I don't see it used as much for schizophrenia. I've seen up to 1500mg. Like we said the last time, it's a small number, they are still getting prior auth. They not, not getting it We changed it from before when they couldn't even get a medication above this. Olanzapine, 30mg is typically the max that I see. Potentially, patients may come up to 50mg, but it's not common, it's very rare. In our population, it's a very, very limited amount of people and we usually make changes to them when they come. Dr. Porter: My point being, one reason the doses are where they are is because…If you send somebody to the pharmacy for a higher dose of the agent they may be sent away and told that it's not going to be paid for because the dose is too high. There is kind of a financial cap on higher doses of agents. Dr. Melton: In Medicaid this is not true though, they are open in Medicaid. And just to correct from earlier, it was actually only 128 patients. And basically, in our controlled environment where its open access we only have 128 patients in the entire state that exceed these now. Dr. Grinage: Great, leave it open.	

	Dr. Larson: To leave it be where those 128 that are over, to have that discussion that you are having at this very moment about if it's appropriate or not appropriate. That's why there was a change in the criteria versus having that hard stop. Changing it to have that peer to peer consult. So that it's not a stop saying no you can't have these medications. It would then facilitate to have this conversation that you're having now about going above these limits. Dr. Grinage: I believe that particular mechanism in place is important for patients that fall outside that bell curve we talked about. I don't believe, my experience with that particular patient population, patients that fall outside that bell curve. And that's what I'm saying, a standard of care, what a prudent provider would do. Dr. Melton: And we're not saying that they can't have a dose above this. Dr. Grinage: I understand but you're saying that they would have to go through a mechanism to take a look at that. And where do you draw the line, is my concern. Dr. Adma: Is there a way that the MCOs can think of, obviously Brad is a specialist, he's not the average provider, and I understand his passion. Is there a mechanism that you guys can think of because on one hand we don't want to put road blocks in his practice and at the same time we don't want people out there to prescribe these mega doses. Is there a mechanism that you can think of where you can look at some of the providers, for example I see all the time from practitioners at Children's Mercy Hospital, these are tough autistic kids who are on these different combinations. Where you can isolate the provider and make an exception. Dr. Esslinger: Let's take that back. We'll discuss that among ourselves. Sec. Mosier: And I would like to look for a motion to move forward. Dr. Klingler: One comment, I'm primary care and I don't mean to speak for all primary care. I would say that mechanism is in place. I would say that all of you sitting here are board certified by your governing agency as I am in pediatrics. I have no problem saying that those prior auths may not apply to someone board certified in the specialty of psychiatry but they do apply to someone board certified in general pediatrics. I have no problem with that, I have not done the residency or the board certification that you guys have done. And I have a respect for that. I don't expect you to titrate the oxygen on a newborn 34 week baby and I wouldn't expect you to expect me to titrate these doses outside my field of expertise. You are board certified and I would hope that would mean something, and provide that avenue to maybe be able to prescribe outside these doses without that prior authorization. Dr. Ellermeier: Is there a way that these limits, or maybe some modification, are the baseline for primary	

	care providers and then there are some adjustments made for higher doses allowed for board certified or specialists? I know that may create a problem in how you administer that. Dr. Grinage: It's a standard of care approach. Dr. Larson: Is there a way to set two different limits based on their board certification? Ms. Todd: We do it by NPI. Dr. Esslinger: Dr. Mosier, you had raised a question earlier and maybe we should get back to that. I would like to consider us bringing back some more data. I'm impressed by the fact that there are 128 patients. If we would make a decision yes or no and it's a prior auth requirement, it's not a no decision. For 128 patients, probably good for a year, is that really that big of a burden as opposed to balancing the safety issue, knowing full well that you're a super specialist. With 60% of the docs being primary care and prescribing some of this, maybe we need to lean a little more on the safety. Dr. Grinage: And what I would say, what I put in the email is what I felt was the better balance. If the committee thinks this is a better balance, that's fine, I just happen to disagree with it. I think these are routinely used, fairly safe. I think certainly monitoring needs to occur. I would have some concerns about people outside the psychiatric specialty and maybe you could put limitations there. I can give you the five limits, five changes that I would make and that's the balance that I make because I see that used commonly. It's the risk benefit analysis of how much prior authorization need to occur. Again it's only one hundred and some patients. I see that routinely in the medical malpractice cases I do at the state hospital. It's not just a sub, super special forensic practice. That's why I put in my input about that. But you're right it's a balance of safety versus an ability to get the medication. Dr. Shoyinka: But that's an important perspective and I haven't seen the dose limits and I'd like to see them. Dr. Grinage: Which dose limits? Dr. Shoyinka: The five proposed limits that you sent in. I haven't seen them and I would like to see them. Dr. Grinage: I can just give them to you real quick or if you want to move on. Sec. Mosier: We can provide those. I think there is a couple of options on the table, one is to just move forward with the eight that we have agreement on and a motion to move that forward with the discussion on the rest of this occurring next time. Or, there can be a motion to move all.	

	Dr. Adma: Let's go with the first option. Sec Mosier: Moved, and a Second? Dr. Klingler: Second Sec. Mosier: Ok, I'll start with Nicole. Dr. Ellermeier: Yes Dr. Adma: Yes Ms. Cobb: Yes Dr. Klingler: Yes Dr. Grinage: Yes Dr. Moeller: Yes Dr. Porter: Yes Sec. Mosier: And are you two yeses? I think you have a proxy? Dr. Porter: That's right, I'm Dr. Millhuff also; man I just got a lot smarter. Secretary Mosier: Thank you very much. We'll bring back the remaining five next time. We'll move on to the use of multiple concurrent… Dr. Ellermeier: Sorry to interrupt, should we at least give those limits so we at least know what they are. Sec. Mosier: Yes Dr. Grinage: This is just what I sent out, again this is just from my experience, and hearing what Ty said he's sees as well. Aripiprazole up to 60mg. Olanzapine, I routinely see 40 mg, I don't see 50mg like someone else suggested. The quetiapine 1500mg, pretty regularly. Ziprasidone is 320mg. Dr. Porter: I guess we just voted it in but I also think 24mg Risperdal is high but we just voted it in so I'm ok. Oh, Fanapt 24mg.	

	Sec. Mosier: We will move forward. Dr. Larson: What I have indicated, is that we will move forward with the eight, removing the five that were discussed in the meeting minutes last time and from your email. That the other eight will move forward for having prior authorization exceeding those limits. Dr. Grinage: I'd just say that the newer medications I didn't address because we don't have enough clinical experience in the community to be able to say how people use it. Dr. Porter: I have a separate motion for this category, I realize I'm trying to make work for somebody. I think that all of the antipsychotics belong on this list. Dr. Grinage: I agree Dr. Porter: I don't see why it should be ok to use a 100mg of Haldol if you can't give… Dr. Larson: The only reason, as we talked about it last time. It's just that when reviewing the criteria from other states, there's no consensus in terms of what those are. I just brought these as suggestions, it's definitely open to adding any other medications. Dr. Porter: I would amend my motion, I realize this is rough science but just to get it to say that all the older antipsychotics be included with a maximum dose of 1.4 times, 1.5 times their PDR recommended dose. Dr. Larson: I could definitely bring those next time for review Dr. Adma: Because when we do this it looks like we are only doing this based on cost. Sec. Mosier: Very good, we will move to the use of… Ms. Murff: Can I just ask a question, In my past life as a retail pharmacist; frequently we would have patients who would be getting dose increases. They weren't always taking their medications, they weren't always filling…	
III. B. Prior Authorization Criteria 1. Use of Multiple Concurrent	Sec. Mosier: I'm going to actually interrupt because we do need to move on to the next topic. So use of multiple concurrent antipsychotics. So, Liane. Dr. Larson: So, the changes made were we did include Aristada, a new drug that was released between the	The criteria was divided by age group and voted on separately.

Antipsychotics – Review proposed clinical criteria for adults and children prescribed multiple concurrent antipsychotic drugs.	last meeting and this, and otherwise the only thing that was changed on this was that we changed from saying 'must be prescribed by a psychiatrist' to 'must be prescribed by or in consultation with a psychiatrist'. Clinical Public Comment: - No requests were received. Committee Discussion: Dr. Porter: Can I add a suggestion? The term used for a nurse practitioner's relationship with their protocol physician is 'collaborative'. And I know this isn't only about nurse practitioners, there's other specialties, but with that term, which would cover the physician/NP relationship, suffice to replace consultation? Dr. Larson: And the only reason I went with this is on our prior authorization criteria across the board for DUR, we use the term 'in consultation with'. I don't know if that is the intent in terms of the nurse practitioner. I think in general it just could be for anyone, it was a broader term to be used. If a physician in a family practice then consulted with a psychiatrist, it was just the term we've used across the board, so that's why it was included. Dr. Porter: I guess as long as we were able to define consultation to include the collaborative relationship between a psychiatrist and a psychiatric nurse practitioner for example, I think that would be the same. Dr. Melton: From a PA standpoint, would you guys look at it any differently if it said 'in consultation' or 'in collaboration'? Dr. Shoyinka: No. Dr. Klingler: Can we use both words? Dr. Melton: 'In consultation/collaboration'. Would that capture what you're looking for? Dr. Porter: Yeah, I think I'd be fine with that. It sounds like there's only one person here particularly concerned about this, so I think it'd be nice if we added that. Ms. Cobb: I think it'd be nice too. Dr. Larson: Ok, 'must be prescribed by or in consultation with a psychiatrist'. Dr. Klingler: And do we need to include our colleagues in neurology that are using some of those drugs too?	The criteria for 3 or more for patients over the age of 18 was discussed and voted on first: Dr. Porter made a motion to accept the PA criteria with changes. Dr. Moeller seconded the motion. The criteria were approved unanimously. The criteria for 2 or more for patients under the age of 18 was discussed and voted on second: Dr. Adma moved to accept the criteria. Dr. Ellermeier seconded the motion. The criteria were approved unanimously.

	Dr. Larson: In the meeting minutes when I reviewed them, that was only discussed in the antipsychotics for children under thirteen policy, but definitely could be included here. Dr. Klingler: I would move that. In the pediatric world, the neurologists are using some of those drugs too. Dr. Adma: How about some pediatricians who may get some specialized training may use these, right? So, these antipsychotics for less than six years of age, do you see that? Dr. Klingler: I don't. And I don't mean to speak for every pediatrician, but I'm in a group of eight board-certified pediatricians, and we do not dabble in this area. Dr. Adma: So, talking with let's say Chuck Johnson at KU, he works with developmental pediatrics, but he tends to prescribe there, so there are going to be those subset of pediatricians. Dr. Klingler: Right. Developmental peds and behavioral peds, Dr. Kerschen, Dr. Johnson, there's four or five in the state, I would say would fall into where they do use those for autism and things, along with their colleagues in neurology. Dr. Ellermeier: I guess I want to clarify. We're talking about 3 or more antipsychotics right now, together? Dr. Melton: Yes, this is for 3 or more antipsychotics for adults and two or more antipsychotics for kids, not just one drug. [Many speaking over each other, words inaudible] Dr. Larson: So are we ok with leaving it as 'must be prescribed by or in consultation or collaboration with a psychiatrist or neurologist'? Dr. Moeller: Do we need neurologist for greater than 18? Dr. Ellermeier: And three or more. Dr. Porter: No, I don't think so. Dr. Melton: And just to make sure everybody saw this: this does include the non-atypicals also. Dr. Adma: How do the MCOs see this playing out? So are you thinking that your psychiatrists will, I know it says psychiatrists, medical director, pharmacy director, most of the time if it is a psychiatrist prescribing,	

	it might be better for your psychiatrists to have the peer-to-peer, right? Dr. Larson: And the discussion we had last time, it was just stated as psychiatrist, but it was the view of the committee to include more individuals. Dr. Porter: Meaning on the receiving end? Dr. Larson: Yes. Before we did just have it saying psychiatrists, and I believe that was the intent of the MCOs when we had talked with each of the pharmacy directors that it would be with a psychiatrist, but to make sure that, for the expediency of getting that PA through in case that psychiatrist was not available, the others were added to the list at the last meeting. Dr. Melton: It's a logistical thing, basically. If the psychiatrist is out for some reason and we get an urgent request, so that someone else can review it in their stead. But the plan at each of the MCOs is to have psychiatrists look at these. Dr. Klingler: You bring up a good point. We probably do need to include developmental pediatricians, I'm looking back on the last one, there's only a handful in the state, but they probably need to be included along with psychiatrists and neurologists. Dr. Larson: On this criteria or the previous one? Dr. Klingler: On the previous one. Dr. Melton: Ok, we'll make a note on that. Dr. Larson: Any other changes you'd like for me to make on this one, the multiple concurrent antipsychotics? For the greater than 3 for adults, greater than two for children? Dr. Mosier: And if there is no other discussion, I'd like to entertain a motion. Dr. Porter: I move that we accept as just discussed, for 3 or more over 18. Dr. Adma: I second. Dr. Melton: Does that include the whole policy? Dr. Adma: No, just more than 18. We'll go one at a time.	

	Dr. Mosier: Ok, so you want to move on the first part, the greater than 18. We'll do that first. So, Nicole? Dr. Ellermeier: Yes. Dr. Adma: Yes Dr. Klingler: Yes Dr. Mosier: Yes Dr. Grinage: Yes Ms. Cobb: Yes Dr. Porter: Yes, and yes. Dr. Mosier: Now we'll move on to multiple concurrent antipsychotics less than age 18. Dr. Klingler: I would move approval with the addition of neurologist and developmental pediatricians. Dr. Melton: And we'll include the collaboration language. Dr. Mosier: You said neurologist and developmental pediatricians? Is that developmental or behavioral? Dr. Klingler: They're boarded together. Dr. Larson: Ok, how would that be worded? Dr. Klingler: I'm trying to think how they're worded. Dr. Larson: Ok, so the changes I have on this one would be 'must be prescribed by or in consultation/collaboration with a psychiatrist, neurologist, or developmental and behavioral pediatrician'. Dr. Adma: Developmental/behavioral pediatrician. Dr. Melton: Ok, the AAP calls it a developmental behavioral pediatrician, a DBP, with no slash. Dr. Klingler: And that's a separate fellowship and sub-board specialty.	

	Dr. Mosier: Any other discussion or changes? I would entertain a motion. Dr. Adma: I would make a motion. Dr. Ellermeier: Second. Dr. Mosier: Nicole? Dr. Ellermeier: Yes. Dr. Adma: Yes Dr. Klingler: Yes Dr. Mosier: Yes Dr. Grinage: Yes Ms. Cobb: Yes Dr. Porter: Yes, Yes. No, I'll only say yes once. Dr. Millhuff shared some concerns when it comes to the children's stuff. He'd shared some information that was a lot to process just in the last 24 hours about different states and how they're taking on some of the algorithms. So, my guess would be he would not say yes to this, because he had some other ideas he hoped to put to the committee, so I'll just say yes for me. Dr. Mosier: Fair enough. Dr. Larson: So on this particular one, it would be a no? Dr. Porter: Abstain. I wasn't sure if he'd go along with that or not.	
III. B. Prior Authorization Criteria 2. Antipsychotics For Children Age 13 or	Dr. Mosier: So antipsychotics for children age thirteen or younger. Dr. Larson: And the changes that we made to this one were again, adding the Aristada, and must be prescribed by or in consultation with a psychiatrist or neurologist. And then also we added height to the	Dr. Adma made motioned for approval.

Younger – Review proposed clinical criteria for children age 13 or younger prescribed antipsychotic drugs.	documentation of plasma glucose, lipid screening, weight, height, and waist circumference within the previous three months. The height was added to each of the criteria. It was also extended from a one-time 30-day override was extended to a 60-day override. And, also included the annual physical for renewal must be completed by a pediatrician or a family practice physician for continued approval. Clinical Public Comment: - No requests were received. Committee Discussion: Dr. Klingler: Could we add our friends in behavioral developmental in there too please? Dr. Moeller: And I think as we discussed earlier, could we consider adding the typical agent because it's a good point that if they can't prescribe an atypical, we're going to see typicals used, but then the height and weight stuff. Dr. Porter. It's not as important. There aren't guidelines for typicals and metabolic, although the low-potencies like Thorazine and Mellaril did cause weight gain, it just hasn't been… Dr. Moeller: ….documented. Dr. Porter: We don't have a particular guideline. I do think though that if we're just looking at metabolic monitoring, that's one thing. But if we're looking at the in general practice of giving these meds to these age groups, the typicals should be included. Dr. Melton: So, do we want to use the same list for this policy that we used for multiple concurrent antipsychotics, in terms of the agents that are included? Dr. Grinage: Yeah, that included most of the typicals. Dr. Melton: Ok, if we're missing anything, let us know. Dr. Grinage: I couldn't find one. Dr. Porter: We're not just looking at the monitoring, we're also looking at the diagnosis. So I'm thinking that because of that, the typicals have to be on here also. Dr. Melton: And we could add a sub-bullet that says 'for use of atypical antipsychotics, documentation of plasma glucose…' We could make it exclusive to those.	Dr. Porter seconded the motion. The criteria were approved unanimously.

	Dr. Porter: I'll just throw it out there. It's one of those things where lack of information doesn't mean that something's safe, and we just never looked at it before. It might be fine, given the small numbers we're looking at, the age group we're looking at, the fact that the older low-potency agents did cause weight gain, it might be just as well to include them all the same. Dr. Grinage: I would recommend we leave in the metabolic parameters. I mean, we didn't get EKGs for tricyclics back in the day either, but you better do it now. So, we have a much broader awareness of metabolic effects, so I would recommend that we keep it. Dr. Adma: On the metabolics, is there a possibility of having the overrides in place if there are sometimes, patients refuse. They are psychotic enough that they say 'I don't want to go' and you can't force them to go. So, on one hand, do we deal with the issue of 'I'm not going to fill the prescription', so is there anything the pharmacist can put in if the patient refuses? Dr. Esslinger: That would be one of those things, Dr. Adma, that if I'm the behavioral health medical director at the plan, and you tell me that, I'm going to probably say yes. But, I think we have to hear that or have it documented. Dr. Adma: Ok Dr. Melton: So, could we add a fourth bullet that says 'cases that do not meet the above criteria require peer-to-peer consultation'? Because that way, if there was some outlier case… Dr. Grinage: I would say 'prior approval'. If you have a case of a person who's refusing appropriate medical workup for a medication but yet you feel that the benefit overrides the risk, there would be no problem justifying that. Dr. Melton: Yeah, so you'd have to do the consultation and then at the health plan, they could say 'Ok, we understand the extenuating circumstances, we'll go ahead and approve the prior authorization.' But that would give a mechanism, not just for the lab things, but if we had a patient with some obscure diagnosis, that would give a mechanism for those cases to be captured as well, and you know a means for approval and for the patient to go ahead and receive the medication even though their case is an outlier. Dr. Esslinger: I don't know that we need to state it, to me that's part of the peer-to-peer discussion. If there is a rejection of a script, any and all issues including patient refusal can come up during that dialogue. Dr. Melton: Ok, I agree. Dr. Ellermeier: So, these don't initially require a peer-to-peer the way the criteria is written now. They just	

	have to meet the check boxes and then the thought is that if they don't meet those check boxes, that we have a process for peer-to-peer then. Dr. Adma: But it doesn't say anything about peer-to-peer until we come down to here, it says 'peer-to-peer consult'. But for less than six, and under thirteen, it doesn't say anything about peer-to-peer. Dr. Ellermeier: I think the point is not to require the peer-to-peer for patients that meet this criteria, but to have the peer-to-peer as an option for outliers. Dr. Melton: The goal of this one was, I can't remember who mentioned it earlier, but this was supposed to the easy check box one. 'Yes, we did the labs, yes, here's the ICD 10, and you're done.' Dr. Esslinger: Keep in mind, any time there's a non-authorization, there's a standard appeals process, whether it says it here or not. Any denial of a prescription or service, there's an appeals process. Dr. Adma: I would ask the committee to look into the diagnosis listed here and consider the following changes: autistic disorder to remain the same, strike out the hyperactive behavior, mood disorder to remain the same, strike off problem behavior severe, strike off schizophrenia, instead use psychosis NOS, keep Tourette's syndrome, but add tic disorder/Tourette's syndrome, and then add severe agitation/aggression. Dr. Porter: I'd only slightly amend that. The NOS thing went away a couple weeks ago, so I think we'd have to call it psychotic disorder. Dr. Grinage: It's like a mood disorder. You'd be using it for bipolar, but calling it a mood disorder. Dr. Larson: So call it psychotic disorder? Dr. Porter: On everything, I completely agree, just take the NOS off. Dr. Shoyinka: I agree with everything you said except that last one, the severe agitation. That sort of leaves the door open a bit, I think. Dr. Porter: I think the problem is, we're talking about usage in a group that most of us, that's not represented in the panel here, and this would be non-psychiatric, these would be developmental patients for the most part, severe MR, et cetera, that don't have autism but are aggressive. Dr. Klingler: Genetic disorders Dr. Porter: Right	

	Dr. Klingler: I think in the pediatric world, that's probably a very appropriate thing to have in there. Dr. Ellermeier: Under six? Would you agree that that's still appropriate? Dr. Esslinger: My only question is how loose or tight would the diagnoses of agitation, aggression be? Dr. Shoyinka: Exactly, it's pretty subjective. Dr. Porter: The question being if you say 'developmental disability' or 'intellectual disability', you don't give people antipsychotics for their intellectual level, you're giving them to them for their violent or problematic behaviors. I think we all want the same thing, it's just how to put it. Dr. Shoyinka: I mean, I agree with the idea, it's just the… Dr. Adma: I agree, I know where you're coming from. The challenge is we don't want to label somebody. Dr. Porter: Is 'problem behavior severe' somehow better? Dr. Esslinger: In this group, I would not have any problem at all with it. In the larger group, where 60% are prescribing it, I'm concerned too, I agree with Dr. Shoyinka's concerns. Dr. Grinage: Well cause I think that's one of the concerns also nationwide that this class of medications is used to treat behavior rather than to treat a disorder per se. So I think if we add that diagnosis then it opens up that entire problem. Dr. Porter: My point being we were thinking about replacing the term 'problem behavior severe and hyperactivity'. Are those better and more specific terms than aggression? You would think they're actually probably less specific maybe. Dr. Shoyinka: Yes, I do. I do think so. Dr. Klingler: I guess the kids I'm thinking of with aggression are the kids down at Heartsprings, the kids that are in the B&D classrooms in our communities, that are truly aggressive and dangerous to themselves and others, not the bully on the playground. But, I understand where you're coming from that they may give this to the bully on the playground. Dr. Esslinger: One phone call, you tell us that, and you're good for the rest of the year.	

	Dr. Shoyinka: So the scenario that's informing what I'm saying right now is a kid, with a discussion with the PCP somewhere in Salina I think or that area, who had a five-year-old on 20 mg of Zyprexa. He had not considered an ADHD diagnosis, he had not screened him for any developmental disorders, he had not done it, he had not considered behavioral therapy, or he had but didn't have the resources for it. The kid had agitation, and it was severe agitation, but that was not appropriate treatment for him. So that's where this is coming from. Dr. Grinage: Well yeah, and I reviewed a case of a three-year-old that died on 20 mg of Olanzapine and 30 of Strattera. Those cases, I don't know how to drill down to protect from that. I do think that intellectually disabled folks that aren't going to get any better, that have long-term problems, you may use a long-term solution like this to manage their behavioral problems, especially to be able to keep them in a home or what not. But I don't know how to say that. Dr. Klingler: And we protected ourselves against your concerns though by the statement above about who can prescribe. Because general pediatrician ain't anywhere in that statement, unless it's in consultation with a psychiatrist. Dr. Adma: So yeah, I think that's a good point. Dr. Klingler: We've covered that base. That would keep the Salina example, unless they had been collaborating with someone in the psychiatric or behavioral field. Dr. Grinage: The case that I saw was a psychiatrist. Dr. Shoyinka: It was a psychiatrist? Dr. Grinage: It was. Dr. Porter: Well, we had a motion about changing the criteria, and then we had a lot of discussion about it, and I'm not sure where we are at with it. Dr. Larson: So, the changes I have listed would be including the DPB in conjunction with psychiatrist and neurologist, the changes to the diagnosis that have been discussed including taking out the 'psychosis NOS' and changing that to 'psychotic disorder', in addition to the other ones that Dr. Adma spoke about. Dr. Mosier: If you'll review those. Dr. Larson: So what I have listed is autistic disorder, mood disorder, psychotic disorder, tic disorder or Tourette's syndrome, and severe agitation/aggression.	

Dr. Shoyinka: I'm sorry; I still have a problem with it.

Dr. Moeller: I agree, I think the severe agitation and aggression is a little too vague and that's one of the big problems with the antipsychotics used in children is that they're throwing them on for severe agitation.

Dr. Ellermeier: And I would agree. And we're talking about kids six and under, so I don't see the harm in requiring a peer-to-peer consult in those cases.

Dr. Grinage: I thought this was age seven to thirteen?

Dr. Ellermeier: I guess it would be both, but I think really concerning is the younger kids we're looking at. I mean, what's the harm of having a peer-to-peer to ensure that it's appropriate?

Dr. Adma: I think what's probably going to happen is it will get labeled as a mood disorder.

Dr. Shoyinka: Yeah, you're right

Dr. Adma: So, I mean, cause we do have 'mood disorder', they'll get diagnosed as having a mood disorder.

Dr. Moeller: So, how do they get diagnosed? Is there a diagnosis of severe agitation?

Dr. Adma: No.

Dr. Moeller: So that's what, I don't even understand how that applies in this thing, because you're going to be looking at data, you're just talking about when they call, right, and say they have severe agitation?

Dr. Grinage: There's an indication.

Dr. Porter: There's an indication for some of the IM meds that are for severe agitation associated with schizophrenia, but they're always associated with a diagnosis.

Dr. Moeller: Like behavioral with autistic disorder?

Dr. Adma: Yeah. I'm ok taking that away, that's ok, we can take away the severe agitation and aggression because they are not psychiatric disorders.

Dr. Klingler: Would you leave behavioral problem severe, then, or would you strike that?

	Dr. Adma: What's that? Dr. Klingler: The behavioral problem severe, would you leave that in or strike it? Dr. Adma: Strike it out. So 'severe agitation and aggression', we're striking it off. And my fear is, as I do that, they'll get labeled as a mood disorder kid and they'll still get prescribed whatever they're being prescribed. Dr. Shoyinka: Or ADHD. Dr. Porter: My concern would be that somewhere out there, there's a physician, psychiatrist, neurologist who's responsible for a long-term care institution of developmentally disabled teens. I don't know how true this is. And maybe, has a half-dozen or all these cases on his case load and will be the one that gets all the burden. And I'd hate for that person to quit their job. Dr. Klingler: I think of back in residency I think of walking through the facility in Wichita that's Heartsprings and what Dr. Kerschen. If you spend any time in that facility, you will see those kids that you're referring to, because we're talking kids with genetic disorders and different things that have many different manifestations of behavioral problems that are treated there. But they're the outliers too, they're there because they are the outlying diagnoses. Dr. Porter: Maybe somebody like that would be identified as a non-bad user. Dr. Grinage: So is this included in the age six or younger? Are we talking about age six and younger now or not? Dr. Adma: Yeah, we are talking about six and younger. Dr. Porter: The criteria would be the same, so… Dr. Grinage: I don't see the criteria for age six or younger as having the diagnostic criteria. Dr. Moeller: It's right here. Dr. Grinage: OK. I've got you. Dr. Moeller: I think—I knew for it to--but I am not motioning, but that it would be the same in the six and in the seven to thirteen.	

	Dr. Larson: So is it agreed upon then that we will strike the severe adjudication aggression. Is that what I am hearing? So it will read: Autistic disorder, mood disorder, psychotic disorder or tic disorder or Turrets syndrome? Dr. Adma: Yeah. Dr. Larson: In both the six and under and seven to thirteen? Dr. Adma: Yeah. Ms. Cobb: And did we need to add the developmental behaviors? Dr. Larson: In both the under six and the seven to thirteen? Dr. Adma: Yeah. Dr. Melton: And the renewal criteria on the back? Dr. Grinage: And I have a question about that as I was not involved with the discussion on that, but is the twelve months for six or younger appropriate? You know we have just been talking about the peripheral use of you know of abuses and uses of these medications as being in the younger population that we are concerned mostly with safety. I don't know. Where did that twelve months come from? Our child guy? Or. . . Dr. Larson: It would originally be six months. So the initial approval will be for six months and then there would be a re-evaluation at the six month mark with this criteria upon approval. Then it would be a twelve. Dr. Grinage: Well, I guess what I am saying is that still continuing in a patient young enough to still be six after six months, should it still be an issue? Should you keep it at six months as opposed to twelve months? I am just wondering where that. Dr. Ellermeier: I think if they have met the criteria once, the diagnosis may change, but unlikely. Most likely the diagnosis is going to be the same. Kelley Melton: Well, one of the other reasons we did it was because of the annual physical. We want to make sure that they are actually seeing a family practice or pediatrician so that . . . Yeah, to make sure their whole health is being looked after. So we did every six months—that could be an issue. Dr. Adma: What is the ADA Guidelines for this glucose –most recent glucose and lipid monitoring? Do	

	we know? Dr. Shoyinka: It is four weeks after . . . it's at base line then four weeks after onset of treatment. Then six months. Dr. Adma: And then? Several voices together: Think it is every five years…think it is twelve… Dr. Moeller: I think—it is baseline—so the glucose, weight and all the basic stuff. It is based on and then at twelve weeks. There might be something like weight, then it is basically yearly. Except lipids, it is every five years. Dr. Adma: Five years. So there is an ADA—so this is not in congruence with the ADA Guidelines, right? Dr. Grinage: Well, I think that is for adults, right? There are not different guidelines for children are there? Dr. Moeller: There is just a general blanket. I don't think it specifies. I don't think they were thinking of children at the time. Dr. Porter: Just a scenario. I guess this would be the process but I guess we will talk about that later. The lists, we are just deciding what meds need reviewing right now. We will talk later about how it will be administered. Dr. Adma: So, what does the committee think about the documentation and the monitoring in consistency with the—you know—if there are any guidelines or AACAP guidelines this would mirror it. So that we are not saying that we are going to overdo it. And, then whoever is practitioner, we are saying these are the guidelines—follow the guidelines. Dr. Grinage: That is a great idea! Dr. Klingler: That is a good idea. It will evolve overtime and you won't have to update as much. Dr. Adma: Yeah. And people are going to question and say why are you asking me to do this when the ADA. Dr. Ellermeier: So you are still proposing upon renewal that they just—it is in line with the current guidelines.	

	Dr. Larson: Or change it to say "documentation of glucose and lipid screenings in accordance with ADA guidelines?" Dr. Adma: Yeah. Dr. Porter: How about we say minimum? In case something changes from what is recommended? Dr. Adma: Metabolic profile monitoring Dr. Larson: "documentation of metabolic –" Dr. Adma: Profile monitoring. Dr. Grinage: That is a great idea. Dr. Esslinger: So they have a reference point though Dr. Larson: In accordance with— Dr. Adma: In accordance with ADA guidelines. Dr. Larson: And I will change it on both the under six and the seven to thirteen. Dr. Porter: I think you said ADA, but I believe we actually—might be American Child. Dr. Adma: So AACAP…you can look up AACAP (American Academy of Child and Adolescent Psychiatry) and see if they have any differences because I think we need to look at that and see if AACAP says anything different. Then we need to stick with AACAP guidelines. Dr. Larson: OK. So AACAP/ADA guidelines? Dr. Melton: So why don't we put this in parenthesis as a reference for the MCOs. Dr. Larson: OK. Dr. Adma: In terms of the evidence based behavior modification—therapy must be, or I mean what if they are not able to for whatever reason? Sec. Mosier: So in the next to end, it says, unless behavioral modification therapy is documented to be	

	ineffective, we could add to that except – Dr. Adma: What if there is a change in foster placement and they are not able to follow –it is not as ineffective… Dr. Ellermeier: So maybe it is ineffective or unavailable? We know that there are access issues in the state. Dr. Melton: As we discussed previously, that's the kind of thing that we could leave to a peer-to-peer consult. If we do have a foster care situation where they are moving a lot, an MCO might be able to help in that case. In saying, here is someone we have that does therapy in the patient's new area—that sort of thing. Dr. Adma: And maybe part of the reason why it's that way it is—is because you again want something definitive. If they don't do it then, approval will be . . . . . Dr. Adma: Do you see any problem with the annual physical, doctor. Dr. Klingler: No. Every child should have an annual physical. It is acceptable between kindergarten and age 10 to go every other year unless you are on medications. Then the AAP recommends an annual physical. Foster care children have to have a physical with every new placement, so some of those kids are getting physicals every six weeks if they get placed. There is no problem with an annual physical and children under three have a different physical schedule that is more intensive then children over three so. Dr. Adma: So on this we are changing the metabolic profile monitoring according to the AACAP or ADA guidelines. We are leaving the rest of this the same except for the consultation with a psychiatrist, neurologist, and developmental behavioral pediatrician. Dr. Klingler: And I will note that I think all three health plans require an annual physical to maintain their eligibility for KanCare and to stay in the health plan so those kids have that paid for and access to that should not be a problem. Dr. Melton: We would like them to do that but they will not lose eligibility if they do not. Dr. Klingler: They won't? Dr. Melton: No. Dr. Klingler: That is covered so they should have no reason not to. Dr. Melton: We monitor. We see what the different rates of annual physical completion elements would	

	have been, but if they don't get it done . . . Dr. Adma: Are we at a point for someone to make a motion? Sec. Mosier: Does anyone want a recap of where we are or? From the top-- Dr. Larson: From the very top, so criteria for anti-psychotics prescribed to children ages six or younger, the changes made from the changes include now the DBP, prescribed in consultation with psychiatrist, neurologist, or DBP. There was the change in the diagnosis to now read autistic disorder, mood disorder, psychotic disorder, tic disorder, or Turrets Syndrome. And then the documentation of plasma, glucose, lipids screening, weight, height, and weight circumference within the previous three months. Then the length of approval would be a one-time 60 day override for the criteria as well. The length of approval would be six months to begin with and then a one-time 60 day override. For the criteria for anti-psychotics prescribed to children ages seven to thirteen—please stop me at any point if there are questions—plus again same diagnosis as the six and under as well as the documentation of plasma, glucose, lipids screenings, weight, height. We do not have any must be prescribed by or in consultation with anyone on that particular age group. For length of approval, 12 months. Dr. Adma: Looking back on that, I want to make sure it is consultation or collaboration, right? Do you have that? Dr. Larson: Yes. With consultation or collaboration, but this does not apply to the seven to thirteen because there is not a diagnosis group for that. Dr. Adma: For six or under? Dr. Larson: Yes. For six and under. Dr. Larson: OK. Renewal criteria for children age six or younger again the change for the prescribers exactly the same; documentation of glucose and lipid screening within the previous six months is changed to documentation of metabolic profile monitoring in accordance with AACAP or ADA guidelines. Patient must be receiving evidence based behavioral modifications stay the same. And then annual physical must be completed by a pediatrician or family practice physician for continued approval with a length of renewal of 12 months. Dr. Adma: How about a nurse practitioner? For annual physical? Dr. Shoyinka: I think that is good.	

	Dr. Klingler: I don't have an opinion. I guess my feeling is that if they are on anti-psychotic medications they probably should see a physician or a nurse practitioner. I would not be in favor of putting a PA or a chiropractor who currently can administer physicals into that category. I think it needs to be an MD or a DO. That is a personal opinion—not an evidence based opinion. Dr. Adma: I think in rural Kansas that is going to… Dr. Klingler: I think that a nurse practitioner— Dr. Moeller: If you are going to do nurse practitioners, why would PAs not be in there? Dr. Klingler: Nurse practitioners have a completely different level of training and function under their own licenses. Dr. Moeller: They don't function under collaboration with a doctor? Dr. Klingler: They collaborate but they function under their own licenses. PAs have two years of education and do not function under their own license. They function under their physician's license. Dr. Adma: But they do physicals all the time? Right? Dr. Klingler: Right. And they would be covered under their physician's. Dr. Moeller: I just think that you are going to hurt one more group. Ms. Cobb: Would that be an access issue? Dr. Moeller: I assume that they are trained . . . Dr. Esslinger: Aren't nurse practitioners required to have a collaboration agreement in Kansas? Several Board Members together: Yes. Dr. Esslinger: OK. Dr. Porter: See you back next legislative session. Dr. Larson: So what would we like this to be changed to?	

	Dr. Adma: My only fear is that it might be an access issue if we exclude a PA that is my opinion. Dr. Ellermeier: Or mid-level practitioner Dr. Larson: Any mid-level practitioner or a specific mid-level practitioner? Because I know that the thought here was that it a . . . Dr. Klingler: A board eligible certified practitioner. Dr. Moeller: I mean we are just talking about the physical that they get. We are not talking about…they are not the ones prescribing the anti-psychotics and all that. Dr. Moeller: Because like sports physicals and things like that aren't they done by PAs and nurse practitioners. Ms. Cobb: I think that the point of the physicals was to make sure they were getting their lab work and you know all else and check and I think that those physician's assistant and nurse practitioners are highly qualified to do that. Dr. Larson: OK. So, we will change it to read annual physicals must be completed by a pediatrician, family practice physician, nurse practitioner, or PA? Dr. Adma: family nurse practitioner or PA. Dr. Moeller: Liane, I think that you also…we forgot to—in the motion we were going to do "typicals" to be included. Dr. Larson: Yes. I am sorry. And, so I did have the full list which would be inclusive if you look at your multiple concurrent criteria, it would be that list there. Dr. Moeller: Just wanted to make sure of that. Dr. Larson: Yes. And I am going to be changing the annual physical requirements for both the under six and the children ages seven to thirteen. So the only difference between the renewal criteria from the under six and the seven to thirteen again would be that the seven to thirteen must not necessarily be prescribed in consultation with a psychiatrist, neurologist, or DBP; but everything else would be the same for both age groups. Dr. Klingler: Liane, I do have one other question. I think we talked about the who's prescribing both with	

	the seven to thirteen as the intention for who's prescribing just to be in the under age six? Or was the assumption that it was also for seven to thirteen year olds? I think I heard discussion both ways and I just wanted to clarify prior to us approving that. Dr. Ellermeier: I think that was just under six. Dr. Melton: And we were just looking at that in terms of it purely just being an access issue. If you look at our numbers from the data earlier, we have quite a few more in that seven to thirteen age group then we do in the under six. Dr. Klingler: OK. I just wanted to clarify. I think the discussion had centered both ways and I wanted to make sure we were all on the same wave length about what we were approving. Dr. Melton: We could always address it if we . . . whenever this is implemented and we start seeing something that is problematic in that age group, you know when they are looking at PAs and we see some kind of pattern. We can bring it back to this group and say we think it might be necessary to go up to seven or eight or something like that but at this point that is how we have it written. Dr. Klingler: OK. I just wanted to clarify to make sure we were all on the same page that was worded different. OK. Dr. Adma: OK. So with all those changes, I make the motion. Dr. Porter: Second. Sec. Mosier: Nicole? Dr. Ellermeier: Yes. Dr. Adma: Yes. Ms. Cobb: Yes. Sec. Mosier: Yes. Dr. Klingler: Yes. Dr. Grinage: Yes.	

	Dr. Moeller: Yes. Dr. Porter: Yes. Dr. Porter: Abstain [For the absent Dr. Millhuff].	
III. New Business A. Prior Authorization Criteria 1. Benzodiazepine Dosing Limits – Review proposed dose limits for patients prescribed benzodiazepines.	Sec. Mosier: We are in overtime. So what I would like to do is just introduce the benzodiazepine dosing limits and we will discuss it at the next meeting unless people want to stay longer. Dr. Melton: The doors close at five. Sec. Mosier: So just to make sure we are out of the building before five. Dr. Melton: Yes. Dr. Porter: I just want to say really quick that this is the thing about the three "benzos," right? Sec. Mosier: Right. Dr. Porter: I think . . . I've got no problem with that. Dr. Larson: So to be quick on the benzodiazepine dosages for those listed basically it would simply be three or more different benzodiazepines used concurrently within thirty (30) days would require a prior authorization which would be a peer-to-peer consult with a health plan psychiatrist, medical director, or pharmacy director for approval; however, patients with seizure diagnosis would automatically be approved. <u>Clinical Public Comment:</u> - No requests were received. <u>Committee Discussion:</u> Dr. Grinage: Moved as is. Dr. Porter: And just as an aside, I'm approving the list. I think we need to spend time on what the process is as I said earlier. So when I am voting yeah, I am not voting for the "how we do the prior authorizations." All right? OK. Sec. Mosier: Any other discussion before we vote? So we have a motion.	Dr. Grinage made a motion to accept the PA criteria. Dr. Klingler seconded the motion. The criteria were approved unanimously.

	Dr. Klingler: Second. Dr. Ellermeier: Yes. Dr. Adma: Yes. Ms. Cobb: Yes. Sec. Mosier: Yes. Dr. Klingler: Yes. Dr. Grinage: Yes. Dr. Moeller: Yes. Dr. Porter: Yes.	
V. Adjourn 4:37pm	Sec. Mosier: So with that we are adjourned.	